Summary Plan Document

Outpatient Prescription Drug Plan

Group Number: Rx 1732

Effective Date: July 1, 2014

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Outpatient Prescription Drug --

This Summary Plan Document provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy.

We want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms of the Summary Plan Document and in Section 3: Glossary of Defined Terms..

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor which is the State of Rhode Island. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Document Section 10: Glossary of Defined Terms. When we use "Administrator", we are referring to CVS Caremark acting as the Pharmacy Benefit Manager.

NOTE: The Coordination of Benefits provision Section 7: Coordination of Benefits in the Summary Plan Document does not apply to Prescription Drug Products.--. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the three tiers of the formulary the Outpatient Prescription Drug is listed.

Coverage Policies and Guidelines

The plan has adopted the prescription Administrator's current formulary, including its preferred drug list, as the Plan's covered formulary. A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The CVS Caremark formulary contains a wide range of generic and preferred brand-name products that have been approved by the FDA. The formulary is developed and maintained by CVS Caremark. Formulary designations may change as new clinical information becomes available. These changes generally will occur quarterly, and may occur without prior notice to you. There are select drugs that are considered non-formulary, non-covered drugs unless you get a prior approval. Changing to a preferred drug alternative, where available, may help you avoid higher copayments. All medications on the preferred list, including generics have been evaluated for effectiveness and safety (e.g., side effects and drug-to-drug interactions).

NOTE: The tier status of a Prescription Drug Product may change periodically as described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.caremark.com, through the Internet, register as a user or call the Customer Service number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified during regular business hours.

You may seek reimbursement from us as described in the Summary Plan Document Section 5: How to File a Claim. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

Designated Specialty Pharmacy

If you require certain Specialty Prescription Drugs, you must use CVS Caremark Specialty Pharmacy to provide those Specialty Prescription Drugs. For more information, contact CVS Caremark Specialty Pharmacy at 1-800-237-2757.

Please see the Prescription Drug Plan -- Glossary for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the heading *Supply Limits*- for details on Specialty Prescription Drug supply limits.

Section 1: What's Covered--Prescription Drug Benefits

CVS Caremark provides Benefits under the Plan for outpatient Prescription Drug Products:

Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network or non-Network Pharmacy.

Refer to exclusions in your Summary Plan Document Section 2: What's Not Covered--Exclusions and as listed in Section 2 of this --.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service and is approved by the F.D.A., unless otherwise excluded.

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

These supply limits do not apply to Specialty Prescriptions Drugs. Specialty Prescription drugs from a Specialty Pharmacy are subject to the supply limits stated below under the heading Specialty Prescription Drugs.

Note: Some products are subject to additional supply limits based on criteria that Administrator has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.caremark.com, register as a user, or by calling Customer Service at the telephone number on your ID card.

Prior Authorization

Some Prescription Drug Products are subject to prior authorization based on criteria that the Administrator has developed, subject to its periodic review and modification. If a drug that you take requires prior authorization, your physician will need to contact CVS Caremark to see if the prescription meets the plan's conditions for coverage.

You may determine whether a Prescription Drug Product is subject to prior authorization through the Internet at www.caremark.com or by calling Customer Service at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table when Prescription Drug Products are obtained from a retail or home delivery pharmacy.

The amount you pay for any of the following will not be included in calculating any Out-of-Pocket Maximum stated in your medical Summary Plan Document.

Copayments for Prescription Drug Products.

Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost. Copayments for a Prescription Drug Product at a non-Network Pharmacy can be either a specific dollar amount or a percentage of the Predominant Reimbursement Rate. **NOTE:** The tier status of a Prescription Drug Product can change periodically When that occurs, your Copayment may change. Please access www.caremark.com, register as a user register as a user or call the Customer Service number on your ID card for the most up-to-date tier status.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: The applicable Copayment or The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products from a home delivery Pharmacy or CVS/pharmacy, you are responsible for paying the lower of: The applicable Copayment or The Prescription Drug Cost for that Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.***

Benefit Information

Description of Pharmacy Type and Supply Limits	Your Copayment Amount

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply:

As written by the provider, up to a consecutive 31-day supply* of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

*At CVS/pharmacy only:

As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

No Copayment applies to Oral Cancer Agents prescribed for cancer treatment.

Oral or injectable chemotherapy drugs, if used for other than cancer treatment and not otherwise covered under the prescription drug section, are covered as a medical service and subject to the medical copayment for both network and non-network coverage.

Your Benefit includes smoking cessation treatment, including the use of an Over-the-Counter (OTC) or prescription FDA approved nicotine replacement therapy, when prescribed by a provider.

All Prescription Drug Products on the formulary are assigned to Tier-1, Tier-2 or Tier-3. Please access www.caremark.com , register as a user, register as a user or call the Customer Service number on your ID card to determine tier status.

$7 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**.

$25 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**.

$45 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Description of Pharmacy Type and Supply Limits	Your Copayment Amount

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your Summary Plan Document of Coverage. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

The following supply limits apply:

As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Oral or injectable chemotherapy drugs, if used for other than cancer treatment and not otherwise covered under the prescription drug section are covered as a medical service and subject to the medical copayment for both network and non-network coverage.

Prescription Drug Products on the formulary are assigned to Tier-1, Tier-2 or Tier-3. Please access www.caremark.com, register as a user register as a user or call the Customer Service number on your ID card to determine tier status.

$7 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**.

$25 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**.

$45 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications

You are responsible for paying a 20% coinsurance for infertility drugs as mandated by RI State law. . RI law defines infertility as "the condition of an otherwise healthy married individual who is unable to conceive or produce conception during a period of one year."

Description of Pharmacy Type and Supply Limits	Your Copayment Amount

Prescription Drug Products from a Home Delivery Pharmacy or CVS/Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a home delivery Pharmacy or a local CVS/Pharmacy location (84-90 day supplies only). The following supply limits apply:

As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

No Copayment applies to Oral Cancer Agents.

Oral or injectable chemotherapy drugs, if used for other than cancer treatment and not otherwise covered under the prescription drug section are covered as a medical service and subject to the medical copayment for both network and non-network coverage.

Out-of-pocket amounts on this benefit will not accumulate to the annual maximum out-of-pocket expense. This benefit level will not increase due to having satisfied the annual maximum out-of-pocket expenses through other buyers.

To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Copayment for any Prescription Orders or Refills sent to the home delivery pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 90-day supply, not a 30-day supply with three refills.

If you choose to fill your prescription at CVS/pharmacy, the prescription must be written for 84 -90 day supplies and the home delivery copayment will apply.

These supply limits do not apply to Specialty Prescriptions Drugs. Specialty Prescription drugs from a mail order Network Pharmacy are subject to the supply limits stated below under the heading Specialty Prescription Drugs.

Prescription Drug Products on the formulary are assigned to Tier-1, Tier-2 or Tier-3. Please access www.caremark.com register as a user or call the Customer Service number on your ID card to determine tier status.

$14 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**.

$50 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**.

$90 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

Note that prescription drug products from a Home Delivery Non-Network Pharmacy are not covered.

You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Specialty Prescription Drugs Benefits are available for Specialty Prescription Drugs Products. If you require Specialty Prescription Drug Products, you must use CVS Caremark Specialty Pharmacy to provide those Specialty Prescription Drug Products. To obtain specialty drugs, call CVS Caremark Specialty Pharmacy at 1-800-237-2767.	All Prescription Drug Products on the formulary are assigned to Tier-1, Tier- 2 or Tier- 3. Please access www.caremark.com register as a user or call the Customer Service number on your ID card to determine tier status.
Step Therapy Certain Specialty Prescription Drug Products for which Benefits are described in this section are subject to step therapy requirements. This means that in order to receive Benefits for such Specialty Prescription Drug Products you are required to use a different Specialty Prescription Drug Product (s) first. You may determine whether a particular Specialty Prescription Drug Product is subject to step therapy requirements by visiting **www.caremark.com, register as a user** or by calling the number on the back of your ID card. Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug. Certain Specialty Prescription Drug Products drugs are subject to a clinical review by CVS Caremark's Specialty Guideline Management program. This program supports safe, clinically appropriate and cost-effective use of specialty medicines. You may determine whether a particular Specialty Prescription Drug Product is subject to clinical review by visiting **www.caremark.com, register as a user** or by calling the number on the back of your ID card.	$14 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product.** $50 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product.** $90 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product** You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications. You are also responsible to pay 20% coinsurance for infertility drugs as mandated by RI State Infertility Coverage. RI law defines infertility as "the condition of an otherwise healthy married individual who is unable to conceive or produce conception during a period of one year."

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Benefits for Preventive Care Medications	Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is covered through the internet at **www.caremark.com** , register as a user or by calling CVS Caremark at the toll-free telephone number on your ID card.

Section 2: What's Not Covered-- Exclusions

Exclusions from coverage listed in the Summary Plan Document apply also to this Plan. --. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
4. Except as specifically provided in your Summary Plan Document under "Section 1: Cancer Therapies Investigational and Lyme Disease, and as specifically provided in the definition of "Prescription Drug Product" in Section 3 of this document, Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Administrator to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. Any product dispensed for the purpose of appetite suppression and other weight loss products.
8. Vaccines, Immunizations and Allergy Serum
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered. Needles and syringes are not covered except for use with insulin.
10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
11. Unit dose packaging of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription drug. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.

16. Any Prescription Drug Product that is considered to be life-style enhancing such as drugs prescribed to treat sexual dysfunction.
17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed unless the Plan Administrator has designated over-the-counter medication as eligible coverage as if it were Prescription Drug and it is obtained with a prescription order or refill from a Physician.
18. The prescription drug, RU-486, or its therapeutic equivalent.
19. Drugs dispensed in violation of state or federal law.
20. Prescription drugs prescribed or dispensed outside of the dispensing guidelines of the Administrator.
21. Blood serum.

Section 3: Prescriptions Appeals Process

A plan sponsor ("Plan Sponsor") of a pharmacy benefit plan ("Plan") may elect to delegate final claims and appeal authority for the Plan to CVS Caremark. In that case, CVS Caremark, acting on behalf of the Plan Sponsor, will provide the following claims and appeals review services:

- Pre-authorization Claim Review Services;
- Pre-Service Appeals Review Services; and
- Post-Service Appeals Review Services.

Definitions
The following terms are used herein to describe the claims and appeals review services provided by CVS Caremark:

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit based on the application of a utilization review or on a determination of a plan member's eligibility to participate in the Plan. An adverse benefit determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate.

Claim – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered Medically Necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
- Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and Use of medication, service or product is not solely for the convenience of the member, member's family, or provider.

Post-Service Claim – A Claim for a Plan benefit that is not a Pre-Service Claim.

Pre-authorization – CVS Caremark's pre-service review of a member's initial request for a particular medication. CVS Caremark will apply a set of pre-defined criteria (provided by the Plan Sponsor) to determine whether there is need for the requested medication.

Pre-Service Claim – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include member requests for pre-authorization.

Urgent Care Claim – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product.

The CVS Caremark Claims and Appeals Process

Pre-authorization Claim Review:
CVS Caremark will implement the prescription drug cost containment programs requested by the Plan Sponsor by comparing member requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled. If CVS Caremark determines that the member's request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations:
If an Adverse Benefit Determination is rendered on the member's Claim, the member may file an appeal of that determination. The member's appeal of the Adverse Benefit Determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the Adverse Benefit Determination.

If the Adverse Benefit Determination is rendered with respect to an Urgent Care Claim, the member and/or the member's attending physician may submit an appeal by calling CVS Caremark.

The member's appeal should include the following information:

- Name of the person the appeal is being filed for;
- CVS Caremark Identification Number;
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Written comments, documents, records or other information relating to the Claim.

The member's appeal and supporting documentation may be mailed or faxed to:

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1866-443-1172
Physicians may submit urgent appeal requests by calling the physician-only toll free number: 1-866-443-1183

CVS Caremark's Review:
CVS Caremark will provide the first-level review of appeals of Pre-Service Claims. If the member appeals CVS Caremark's decision, the member can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization ("IRO").

Timing of Review:

Pre-Authorization Claim Review – CVS Caremark will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, CVS Caremark will make a decision on the Claim within 72 hours of receipt or within two (2) business days after the receipt of all information necessary to complete the appeal, whichever is shorter.

Pre-Service Claim Appeal – CVS Caremark will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the member's appeal. If CVS Caremark renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the member may appeal that decision by providing the information described above. A decision on the member's second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the member is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined) or two (2) business days whichever is shorter.

Post-Service Claim Appeal – CVS Caremark will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives the appeal.

Scope of Review:
During its pre-authorization Claim review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, CVS Caremark shall:

- Take into account all comments, documents, records and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;

- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly-situated members; and
- Provide a review that does not afford deference to the initial Adverse Benefit

Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If a member appeals CVS Caremark's denial of a Pre-Service Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professionals who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination:

Following the review of a member's Claim, CVS Caremark will notify the member of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Authority as Claims Fiduciary:

CVS Caremark shall serve as the claims fiduciary with respect to preauthorization review of prescription drug benefit Claims arising under the Plan, first-level review of appeals of Pre-Services Claims, and review of Post-Service Claims. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. CVS Caremark is not responsible for the conduct of any second-level Medical Necessity review performed by an IRO.

Section 4: Glossary of Defined Terms

This section:
Defines the terms used--. Other defined terms used -- can be found in Section 10: Glossary of Defined Terms of your Summary Plan Document.

Is not intended to describe Benefits.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Administrator identifies as a Brand-name product, based on available data resources including, but not limited to, Medi-Span Prescription Pricing Guide (with supplements), or following notice to Plan Sponsor, any other nationally available reporting service of pharmaceutical prices as utilized by Caremark as a pricing source for prescription drug pricing that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Administrator

Designated Pharmacy - a pharmacy that has entered into an agreement with the Administrator or with an organization contracting on its behalf, to provide specific Prescription Drug Products including but not limited to Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy. Specialty Prescription drugs must be obtained through CVS Caremark Specialty Pharmacy by calling 1-800-237-2767.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that the Administrator Prescription Benefit Manager (PBM) identifies as a Generic product based on available data resources including, but not limited to, Medi-Span Prescription Pricing Guide (with supplements), or following notice to Plan Sponsor, any other nationally available reporting service of pharmaceutical prices as utilized by Caremark as a pricing source for prescription drug pricing that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Administrator

Network Pharmacy - a pharmacy that has:

Entered into an agreement with the Administrator or its designee to provide Prescription Drug Products to Covered Persons.

Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.

Been designated by the Administrator as a Network Pharmacy.

A Network Pharmacy can be either a retail or a home delivery pharmacy.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and sales tax. The Predominant Reimbursement Rate is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost - the rate we have agreed to pay Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this plan. .-- This list is subject to periodic review and modification (generally quarterly). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.caremark.com, register as a user or by calling the Customer Service number on your ID card.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

Inhalers (with spacers).

Insulin.

The following diabetic supplies:

- standard insulin syringes with needles;
- blood-testing strips - glucose;
- urine-testing strips - glucose;
- ketone-testing strips and tablets;
- lancets and lancet devices;
- glucose monitors.

In accordance with the provisions in R.I. Gen. Laws Section 27-55-1, prescription drugs used for the treatment of cancer, even if the drug has not been approved by the FDA for that indication, provided that the drug is recognized for treatment of that indication in one standard reference compendia, or in the medical literature.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or

with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at **www.caremark.com** , register as a user or by calling CVS Caremark at the telephone number on your ID card.

Specialty Prescription Drug -Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug that is used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for infertility. For more information, visit www.caremark.com , register as a user or call CVS Caremark Specialty Pharmacy at 1-800-237-2767

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.